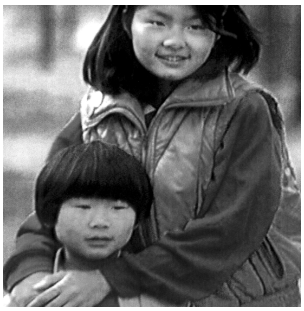
STRENGTHENING THE SAFETY NET

A FINANCIAL ANALYSIS OF NEW HAMPSHIRE'S COMMUNITY HEALTH CENTERS

Individual Community Health Center Reports

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Ammonoosuc Community Health Services, Inc.
Financial Analysis 1994-1999

Summary

Ammonoosuc Community Health Services, Inc. had consistent losses on operations during the period analyzed. Cash flows were typical of many of the CHCs, as the primary source of cash was short-term debt. Ammonoosuc's liquidity and solvency has deteriorated with consistent losses, as both the current ratio and debt service coverage ratio are below 1.

Cash Flows

The primary source of cash for Ammonoosuc Community Health Services, Inc. was increases in accounts payable and accrued expenses (40.5%). Depreciation generated 27.2% of cash. 37.1% of cash used was for property, plant and equipment (PP&E) purchases, although the average age of plant doubled (from 3.4 to 7.3 years) during the period analyzed. In addition, 32.5% of cash was used to finance an increase in accounts receivable, while operating losses consumed 20.0% of the cash.

Profitability

Ammonoosuc had consistently negative operating and total margins, with the exception of 1994, when both margins were 9%. Net patient service revenue has never exceeded 36% of total expenses, and was at 27% in 1999. While grants and contracts as a percent of total operating expenses has fallen since 1993, it still exceeds the revenue from net patient service revenue (NPSR) (59% in 1999). Charity care was near 20% of gross patient service revenue (GPSR) for the period 1996-1999.

Liquidity

Liquidity has steadily worsened over the period analyzed. Both the current ratio and days cash on hand are in the lowest quartile of the CHCs in1999, at 0.85 and 2.1, respectively. Both of these ratios have fallen steadily since 1993, and consistently lie among the lowest quartile of all CHCs analyzed. The average pay period has increased steadily since 1993 as well. It currently takes the organization an average of 50.7 days to pay accounts payable and accrued expenses.

Solvency

Although Ammonoosuc did not issue debt between the years 1994-1998, the long-term debt to equity ratio rose steadily as net assets decreased. In 1999, after a small amount of debt was issued ($12,419), Ammonoosuc's long-term debt to equity ratio was 4.2, and its equity-financing ratio fell to 11%. Ammonoosuc is not able to service its long-term debt, as the debt service coverage ratio was below 1 in 1998 and 1999, and cash flow to total debt dropped to 1%.

Source: Audited Financial Statements. Prepared by Jennifer Scott, Paul Giaudrone, and Hyun Ryu under the supervision of Nancy Kane, DBA, Harvard School of Public Health.

Avis Goodwin Community Health Center
Financial Analysis 1993-1999

Summary

Avis Goodwin Community Health Center has experienced erratic profitability during the period 1993 to 1999. Although net income was a source of cash for the organization, the majority of cash generated was from slowing down payment of short-term liabilities. As short-term debt was used to purchase long-term assets, Avis Goodwin's liquidity worsened. The amount of assets financed with equity has also decreased during the period analyzed, and the Center's cash flow to total debt is low, signaling difficulty in covering both long-term and short-term debt.

Cash Flows

48.3%, or approximately $500,000 of Avis Goodwin's cash was generated from slowing down payment of accounts payable and accrued expenses. Depreciation and net income generated 35.0% and 14.6% of Avis Goodwin's cash, respectively, although the majority of cash from net income came in 1994, when the Center had a 9% operating margin. 44.5% of the cash generated was used to purchase property, plant and equipment (PPE), and 29.7% went into patient accounts receivable.

Profitability

Increases in operating revenue and expenses have been uneven, which resulted in erratic profitability margins. Net patient service revenue and grants and contracts together account for approximately 100% of total operating expenses in all years examined, although NPSR as a percent of total operating expenses has decreased from 53.0% to 37.8%. Data for charity care was available for 1998 and 1999, and went from 32% to 37% of gross patient service revenue in those years.

Liquidity

Avis Goodwin's liquidity position has worsened from 1993 to 1998, although some ratios improved in 1999. For example, average payment period and days in accounts receivable were reduced to 78.9 and 100.4 days in 1999, after values of 165.9 and 90.8 in 1998. The current ratio has remained steady in the three most recent years (1.38 in 1999), after falling from 3.1 from 1993 to 1996.

Solvency

During the seven-year period, Avis Goodwin has financed an increasing amount of its net assets with short-term liabilities. This is highlighted by the equity-financing ratio, which decreased from 52% in 1993 to 37% in 1999. This ratio is below the median for the CHCs. Cash flow to total debt has ranged from –1% to 15% (excluding 1996), and signals difficulty in paying short and long-term liabilities from operating sources.

Source: Audited Financial Statements. Prepared by Jennifer Scott, Paul Giaudrone, and Hyun Ryu under the supervision of Nancy Kane, DBA, Harvard School of Public Health.

Coos County Family Health Services, Inc.
Financial Analysis 1994-1999

Summary

Coos County Family Health Services has experienced consistently positive operating and total margins during the years 1994-1999. The majority of cash sources for the organization came from operations and was used for property, plant and equipment (PP&E) purchases. Although collections of accounts receivables are slow, the payment of short-term obligations is among the best of the CHCs. As total liabilities increase at a much higher rate than net assets, cash flow to total debt and the equity-financing ratio are below the CHC medians.

Cash Flows

58.5% of Coos County's cash came from depreciation (34.0%) and net income (24.5%). Although 17% of the organization's cash was from increases in accounts payable and accrued expenses, this occurred primarily because the Center had a high rate of growth. Investment in property, plant and equipment (PP&E) consumed 59% of cash generated over the period. Most of the remainder of the cash was used to finance an increase in accounts receivable (37.9%).

Profitability

Both Coos' operating and total margins have been steady for the years 1996-1999, at 2%. Net patient service revenue has increased as a percent of total operating expenses during the period, from 25% to 45%. Coos depends less on grants and contracts in 1999 than they did in previous years, as the percent of this revenue source to operating expenses has decreased from 89% in 1993 to 53% in 1999.

Liquidity

Even though a significant portion of Coos' cash has been drained from a slowdown in collection of accounts receivable, Coos is one of the fastest of the CHCs in paying off accounts payable and accrued expenses. Days in accounts receivable and the average pay period in 1999 were 127 and 26 days, respectively. Coos current ratio was erratic during the period and days cash on hand has declined due, in part, to the slow collection of receivables.

Solvency

As Coos has issued a significant amount of debt during the period (including over $1 million in 1999)[1], the organization's liabilities have increased at a faster rate than its net assets. Thus, Coos' equity financing ratio has declined from 45% in 1996 to 24% in 1999, and the organization's cash flow to total debt declined from 50% in 1993 to 7% in 1999.

Source: Audited Financial Statements. Prepared by Jennifer Scott, Paul Giaudrone, and Hyun Ryu under the supervision of Nancy Kane, DBA, Harvard School of Public Health.

[1] Coos County Family Health Services sought and secured capital financing for facility expansion.

Families First of the Greater Seacoast
Financial Analysis 1993-1999

Summary

Families First of the Greater Seacoast has maintained a positive total margin over all but one year (1996) since 1993, although operating and total margins decreased dramatically during the years 1993 to 1996. Families First maintains a current ratio and days cash on hand that are in the top quartile of the CHCs, and has transferred much of its cash into board designated assets. [2] Families First did not repay or issue long-term debt during the period analyzed. [3]

Cash Flows

During the period studied, Families First generated 27.7% of its cash from net income, and 9.2% of cash from accounts payable and accrued expenses. Collection of accounts receivable slowed, using 19.9% of the cash generated. However, the largest sources and uses of cash came with the transfer of existing cash into board-designated assets. Over the seven-year period, board designated assets grew by $250,920, while current cash went down by $206,947. Overall, increases in board-designated funds used 71.1% of cash generated.

Profitability

Both total and operating margins for Families First have fallen rapidly during the first four years analyzed (1993-1996). Although Families First continued to lose money on operations during 1997 and 1998, investment income prevented a net loss. In 1999, Families First had positive total and operating margins, and net income approached that of 1993 and 1994. Charity care as a percentage of gross patient service revenue increased from 16% in 1997 to 25% in 1999 (data available only for 1997-99).

Increases in the organization's operating revenue and expenses have been dramatic during the period analyzed, with the exception of 1996, when operating revenues decreased by 4% and expenses increased by 1%. Net patient service revenue as a percent of total operating expenses declined steadily, from 41% in 1993 to 21% in 1999. This decrease was mirrored by an increase in grants and contracts revenue as a percent of total operating expenses.

Liquidity

The liquidity position of Families First has decreased with its declining profitability and with shifting of cash to non-current, board designated accounts. However, the organization still maintains a current ratio and days cash on hand (both including board designated assets) that is in the top quartile of the CHCs (7.7 and 113.7, respectively). Days in accounts receivable was among the best of the CHCs in 1993 (30.3 days) but has

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[2] Interest from these board-designated assets is used to fund operating costs.

[3] Families First moved into new quarters - the Community Campus - in 1999. The Community Campus houses a number of health, education and social service organizations that serve area families. These organizations pay below market rents for their space.

steadily slowed, such that by 1999 Families First was in the slowest quartile for this ratio (132.3 days).

Solvency

During the period analyzed, Families First maintained a steady equity-financing ratio of 84-90%. No long-term debt was issued during this time, and the organization has not purchased property (see footnote 2). Although the cash flow to total debt ratio has been erratic, Families First had sufficient cash on hand to repay existing short-term debt, and to purchase a small amount of equipment.

Source: Audited Financial Statements. Prepared by Jennifer Scott, Paul Giaudrone, and Hyun Ryu under the supervision of Nancy Kane, DBA, Harvard School of Public Health.

Health First Family Care Center
Financial Analysis 1998-1999

Summary

Health First Family Care Center has run a deficit in the fiscal years 1998 and 1999, one and a half years after it was established. 82.2% of the organization's cash was generated from accounts payable and accrued expenses, and the Center's accounts receivable balance grew (a use of 62.1% of cash). Health First's net assets have been depleted to below 0, and the Center's current ratio was 0.8 in 1999.

Cash Flows

In addition to using cash to finance an increase in accounts receivable, 24.2% of Health First's cash was used to support operating losses. The largest sources of cash include accounts payable and accrued expenses (82.2%) and depreciation (15.0%).

Profitability

During 1998 and 1999, Health First had operating losses of 3% and 5%. After increasing operating revenues and expenses in 1998 by 2.5 and 3.8 times, respectively, both operating revenues and expenses decreased in 1999.

Liquidity and Solvency

As accounts receivable collection is slow and Health First's cash reserves have been used to support operations, cash reserves have been depleted to 4.06 days cash on hand. In 1999, net assets were at a deficit of $12,166, and the Center's current ratio was 0.8.

Source: Audited Financial Statements. Prepared by Jennifer Scott, Paul Giaudrone, and Hyun Ryu under the supervision of Nancy Kane, DBA, Harvard School of Public Health.

Lamprey Health Care, Inc.
Financial Analysis 1993-1999

Summary

During the years 1993 to 1999, Lamprey Health Care, Inc. has experienced a breakeven level of profitability that is near the median of all CHCs studied. Roughly $670,000 of long-term debt was issued in 1996, that along with cash generated from short-term debt allowed the health center to purchase new property, plant and equipment (PP&E). Even with this increase in long-term debt (LTD), Lamprey Health Care, Inc. maintains a debt to equity ratio that is near the median of the CHCs. Lamprey's ability to pay off debt is erratic. Much of the Center's current assets are tied up in accounts receivable, although the collection period is well below the CHC median.

Cash Flows

Lamprey generated a significant portion of their cash from speeding up collections of accounts receivable and slowing down payment of short-term obligations (27.7% and 10.9%, respectively). The issue of long-term debt in 1996 generated 21.9% of their cash in the seven-year period. 35.7% of Lamprey Health Care, Inc.'s cash was generated from income (13.3%) and depreciation (22.4%). Most of the cash generated by net income (13.3%) was earned in 1996, which occurred after a favorable settlement with Medicaid.

The majority of the cash used during the period analyzed was for the purchase of property, plant and equipment (PP&E) (71.2%), which also occurred in 1996. Much of the remainder of the cash went to a reduction in deferred grants, a liability account that is reported as a liability in one year, but in the next year, it disappears from the statement without any evidence of having been earned or transferred into operating revenues. (This may be a deficiency in reporting that cannot be fully understood with available information.)

Profitability

Lamprey Health Care Inc.'s profit margins varied around zero for much of the period analyzed. Operating expenses and revenues increased at roughly the same rate, although the make-up of the operating revenues changed. For example, the percent of total expenses that were covered by net patient service revenues decreased from 67% to 56% over the period 1993-1999. Charges for services followed a similar trend, decreasing from 81% to 69% of gross patient service revenue (GSPR) from 1993 to 1998. In 1999, it increased to 90% based on a change in revenue recognition policy.

Liquidity

Lamprey collects its accounts receivables in 46 days, on average, in 1999. This rate is among the fastest of the CHCs analyzed. In 1993, Lamprey was also among the fastest at paying short-term obligations (average pay period of 23.3 days), although payment has slowed to 45.7 days in 1999, now among the slowest to pay. Lamprey has a current ratio of 1.69, which lies near the median of the CHCs. The current ratio has improved significantly since 1996, primarily due to reductions in deferred grants revenue, which as mentioned earlier, is not consistently stated in Lamprey's financial statements.

Solvency

Lamprey's capital structure is average among the CHCs, even though $668,000 in debt was issued in 1996. Lamprey's equity financing ratio was 49% in 1999, falling from a value of 74% following the issue of long-term debt. Lamprey's ability to service debt is erratic, and mirrors profitability.

Source: Audited Financial Statements. Prepared by Jennifer Scott, Paul Giaudrone, and Hyun Ryu under the supervision of Nancy Kane, DBA, Harvard School of Public Health.

Manchester Community Health Center
Financial Analysis 1993-1999

Summary

Financial indicators for Manchester Community Health Center exhibited high variability for the period analyzed. Despite the variability, the Center was one of the top financial performers among the CHCs. [4] For example, the operating margin was consistently above 5%, although in 1997 operations incurred a 13% loss. All liquidity and solvency values varied dramatically over the 7-year period, and the majority of these indicators placed Manchester among the top quartile of financial performance. Sources and uses of cash flows also represent financial health, as Manchester paid off remaining long-term debt primarily from net income (51% of cash sources).

Cash Flows

86.8% of the sources of Manchester's cash were from operations, including net income (51.3%) and depreciation (35.5%). 26.6% of the uses of cash included settling a deferred liability account in 1994. Manchester used 24.6% of its cash to pay off its long-term debt and 15.6% to increase cash reserves.

Profitability

Manchester CHC's operating margins varied between –13% and 16%. However, the two extremes came in 1997 and 1998, so they may be related to a mismatch of revenues to expenses in the two years (see footnote 1 re: the 1998 Medicaid settlement). Gross patient service revenue dropped 2% in 1997 and increased 37% in 1998, while operating expenses increased 13% and dropped 2% in those years. Ignoring the extremes in margins, Manchester's operating margin varied between 2% and 8%. Charity care as a percent of GPSR ranged between 13% and 23%.

Liquidity and Solvency

All liquidity ratios improved dramatically over the period. By 1999, days cash on hand (88.1), days in accounts receivable (53.8), average pay period (21.6), and current ratio (6.71) all were in the top quartile of the CHCs. In 1999, Manchester had enough cash in its reserves to pay off all liabilities four times over and had only $968 in long-term debt. [5] Cash flow to total debt (1.33) and equity financing ratio (81%) were in the top quartile of the CHCs.

Source: Audited Financial Statements. Prepared by Jennifer Scott, Paul Giaudrone, and Hyun Ryu under the supervision of Nancy Kane, DBA, Harvard School of Public Health.

[4] Manchester CHC had an operating margin of 16% in FY 1998 due to a Medicaid settlement and vacancies in the CEO, CFO and Medical Director positions.

[5] The Manchester CHC board elected to designate the Medicaid settlement funds in net assets to establish a capital reserve for facility and capital improvements.

Neighborhood Health Center of Greater Nashua (now Lamprey Health Care)

Financial Analysis 1993-1999 [6]

Summary

Operating losses in 1998 and 1999 for Neighborhood Health Center of Greater Nashua have depleted net assets and challenged the going-concern of the organization. 47.2% of the organization's cash flows have gone to support this operating loss, and the primary source of the cash flows were from accounts payable and accrued expenses. Neighborhood Health Center of Greater Nashua is currently seeking outside funding to support its operations and remain solvent.

Cash Flows

Cash sources include accounts payable and accrued expenses (47.6%) and a line of credit drawn upon in 1997 and 1998 (23.0%). This cash has primarily been used to support a loss in operations (47.2%) and to purchase property, plant and equipment (PP&E) (14.5%). 17.1% of cash has been used to finance an increase in accounts receivable.

Profitability, Liquidity and Solvency

Between the years 1993 to 1997, Neighborhood Health Center had a steady operating margin, ranging from 1% to 3%. However, the organization reports that as 70% of the payer mix is uninsured patients, it is no longer able to support operations. Funding is being sought to remain solvent, and the organization is seeking forgiveness of accounts payable from vendors. In 1999, Neighborhood Health Center was technically bankrupt, with a current ratio of 0.8.

Source: Audited Financial Statements. Prepared by Jennifer Scott, Paul Giaudrone, and Hyun Ryu under the supervision of Nancy Kane, DBA, Harvard School of Public Health.

[6] As of September 2000 the Neighborhood Health Center ceased to exist as an independent entity and became part of Lamprey Health Care, Inc. Lamprey (a FQHC) received Section 330 expansion funds (from HRSA/Bureau of Primary Health Care) and a Community Grant Program award (through the NH Department of Health and Human Services) to help it accomplish this consolidation.